



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

KYLE E JONES, MD
1025 DESHONG DRIVE
PARIS, TX 75460

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-0964-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Extent of injury was in question. Rule 130.6(B)(5) states when extent of injury is in question, the DD shall provide multiple cert. of MMI & IR that take into account the various interpretations of the extent of injury."

Amount in Dispute: \$50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor billed code 99456-MI, WP for multiple impairments. However, there is no documentation of multiple impairments. Therefore no payment was made."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Hwy 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 20, 2011	99456-MI-WP	\$50.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 23, 2011

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- 225 – THE SUBMITTED DOCUMENT DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Explanation of benefits dated September 15, 2011

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
- 225 – THE SUBMITTED DOCUMENT DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Explanation of benefits dated November 01, 2011

- CAC-W1 WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
- CAC-18 – DUPLICATE CLAIM/SERVICE.
- 225 – THE SUBMITTED DOCUMENT DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
- 736 – DUPLICATE APPEAL. NETWORK CONTRACT APPLIED BY THE TEXAS STAR NETWORK. CALL 1 800-381-8067 FOR RECONSIDERATION DISCUSSION
- 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTIONS/INSTRUCTIONS.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement for disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor (DD) billed \$50.00 for CPT Code 99456-MI-WP for a Multiple Impairment Rating (IR) examination as an additional line item to a MMI/IR examination CPT 99456-W5-WP for \$500.00 which was paid and is not in dispute. The Division ordered a DD exam to be performed per Texas Labor Code §408.0041 which states in (h)(1):

“(h) The insurance carrier shall pay for:
(1) an examination required under Subsection (a) or (f).”

and the Texas Labor Code §408.0041 states in part (a)(1)(2):

“(a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:

- (1) the impairment caused by the compensable injury;
- (2) the attainment of maximum medical improvement;”

The reimbursement of the examination components is subject for review under 28 Texas Administrative Code §134.204. Review of documentation does not support that any multiple impairment rating certification was done. The narrative report states, “Since the claimant has not yet reached the point of MMI if disputed areas are included, an impairment rating is not yet assessed in this case.” No multiple impairment rating was documented.

2. The requestor is not entitled to reimbursement for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	January 13, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.